Hospital	Base Year
A	4.03
B	3.45
C	3.31
D	3.26
H	3.95

The allowable target of this five-hospital sample is the sixtieth percentile, Hospital B, at 3.45 employes per factored patient day. Therefore, Hospital H is 0.5 FTEs per factored patient day over the target. The Medicaid disallowance would be computed as follows:

1. Convert the excess FEPPD into FTE by use of the formula:

$$FTE = \frac{FEPPD\ (TPD + OPE)}{365}$$

or

$$FTE = \frac{0.5(135.2 + 12.31)}{365} = 0.2.$$

2. Find the percentage that the total compensation of the excess FTE is of the total operating costs of the hospital in the base year (Column 3, Line 80, Schedule A of the Medicare Cost Report).

   Assume that Hospital H had in the base year:

   a) Average total compensation per employe of $20,000; and

   b) Total operating costs of $58,000.

   Then the percentage of excess compensation for Hospital H is

$$\frac{0.2 \times \$20,000}{\$58,000} = 0.069 = 6.9 \text{ percent.}$$

3. Finally, compute the Medicaid disallowance by applying the above percentage to the Medicaid inpatient and outpatient costs in the base year (Form E-5).

   Let us assume that Hospital H had Medicaid inpatient costs of $3,900 and Medicaid outpatient costs of $800; then the disallowance is:

$0.069 \times \$3,900 = \$269.10$ = inpatient disallowance
$0.069 \times \$\ 800 = \ 55.20$ = outpatient disallowance
$\$324.30$ = total disallowance

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APPENDIX IV

TARGET FOR FOOD COSTS PER INPATIENT DAY

I. Introduction

Food costs is a category that has sufficient payback to warrant hospital-wide evaluation, has little quality of care or acuity of care considerations, and is easily measured. All hospitals must feed their inpatients nutritious and diet conforming meals. There are no exceptions. Therefore, the major differences in food costs from one hospital to another are the type and amount of food served and the purchase price of the food.* Since the purchase price of food can be dependent on the size of individual food orders, the food costs target will be implemented by bed size.

II. Methodology

The following steps will be used for deriving a food costs per inpatient day target for each hospital.

STEPS:

A. From the base year Medicaid Cost Report, take total food costs from Supplemental Worksheet H, Line 5.

B. Divide total food costs by base year inpatient hospital days from either supplemental Worksheet I, Part III, Patient Days Column, Total Hospital Line or Page 3 of the Cost Report, Line 6, all columns, as applicable.** (Nursery days should not be included.)

C. Adjust the Step B result to the same fiscal year end for all hospitals. The fiscal year end to be used is December 1981 (4th quarter).

D. Compare the Step C result by hospital bed size components. The bed size components to be used are 99 or fewer beds, and 100 beds or over.

For those hospitals that exceed the adjusted food costs per inpatient day maximum, proceed to the following steps.

*One exception may be Mt. Sinai Hospital in Milwaukee and their purchase of kosher foods for dietary purposes.

**If the provider is a combination hospital/nursing home and has not presented hospital-only costs, then nursing home days must be included in summing total inpatient days.

E. Calculate the effect on total expenses of the hospital exceeding the target and obtain a percentage effect by taking total food costs over the target [cost/inpatient day over the target times total inpatient

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days (excluding nursery)] and dividing by total base year operating expenses.

F. Take the percentage effect derived in Step E and apply to base year Medicaid expenses to determine the Medicaid effect.

Appendix IVA lists the data requirements and their corresponding source documents for implementing this target; Appendix IVB shows a hypothetical example.

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APPENDIX IV A

DATA REQUIREMENTS FOR THE FOOD COSTS/INPATIENT DAY TARGET

DATE	SOURCE
1. Total Food Costs	1. Supplemental Worksheet H, Line 5.
2. Total Inpatient Days	2. Supplemental Worksheet I, Part III, Column 2, Total Hospital Line.
3. Fiscal Year End	3. Top right-hand corner of nearly every page of the cost report.
4. Fiscal Year End adjustments factor to bring all hospitals forward or backward to FYE 12/31/81 for food costs	4. DRI Food Costs Index, increase/decrease for the number of applicable quarters.
5. SMSA/Non-SMSA designation	5. Routine Cost Limit Handout: Column 2.
6. Hospital Bed Size	6. Supplemental Worksheet I. Part III, Approved Beds Column, Total Hospital Line.

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APPENDIX IV B

ILLUSTRATION

Hospital	City	FYE	Bed Size
ABC Hospital	Racine	6/30/81	216

1. Total food costs $554,172
   Total inpatient days (excluding nursery) 70,613

   $\frac{\$554,172}{70,613}$ = $7.85/Food Cost per Inpatient Day

2. Since all hospitals will be brought to a December FYE, using the DRI published food costs index, a six-month (two quarter) adjustment is necessary for ABC Hospital (a 6/30/81 FYE hospital). Assume that the six-month food cost increase from the second quarter of 1981 to the fourth quarter of 1981 is 5 percent.

   $7.85 x 1.05 = $8.24 Adjusted Food Cost per Inpatient Day

3. Assume there are 10 SMSA hospitals in the state with beds between 100 and 404 (the range within which ABC hospital falls) with the following FYE adjusted food cost per inpatient day.

Hospital A	$9.00
Hospital B	8.10
Hospital C	7.00
Hospital D	7.50
Hospital E	7.75
Hospital F	8.50
Hospital G	8.00
Hospital H	7 25
Hospital I	7.90
Hospital ABC	8.24

The allowable target for this ten-hospital sample is the sixtieth percentile, Hospital G, at $8.00 food costs per inpatient day.

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Therefore, ABC Hospital is $.24 per inpatient day over the target ($8.24 - $8.00), when evaluating the hospitals on a comparable fiscal year basis. Since ABC Hospital has a base FYE of June, the amount of per diem costs must be deflated by the six-month percentage food increase referred to in Step 2. This results in ABC Hospital being $.23 over the target ($.24/1.05) or $16,241 of excess food costs ($.23 x 70,613 days) being taken out of base year total operating expenses.

To obtain the Medicaid effect, take the excess food costs of $16,241 and divide by total operating expenses of $22,000,000 for a percentage effect of .07 percent. Multiply the percentage effect by base year Medicaid inpatient costs of $2,800,000 to get the base year Medicaid adjustment. The base year Medicaid adjustment of $1,960 for inpatient costs would then be indexed forward using the hospital cost index to determine the Medicaid effect in future years.

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APPENDIX V

ROUTINE SERVICE COST LIMITATION - EEO ADJUSTMENT

I. Introduction

The current Medicaid hospital system has a built-in factor reimbursement for limiting routine costs to reasonable levels, namely the routine service cost limitation (RSCL). Since Federal regulations have been changed so that reimbursement can reflect efficient and economically operated (EEO) considerations rather than reasonable costs, it is appropriate to re-evaluate the RSCL in light of this new reimbursement guideline. Routine service costs typically represent 40 to 50 percent of total inpatient costs. Routine services consist of the food, nursing, minor medical and surgical supplies, and use of equipment and facilities for which a charge is usually included in the room rate. These routine service costs are often referred to as the "hotel" costs associated with the patient's stay. Routine costs, as the name implies, are fairly uniform among hospitals, making comparisons of costs possible. (On the other hand, ancillary costs vary across hospitals depending on the types of service provided and the case mix.) In developing the RSCL, HCFA employed peer grouping on a national level so that similar hospitals could be compared. Hospitals were grouped according to bed size, location within a SMSA/Non-SMSA, and the per capita income of the surrounding area. For the base year of the current system, the routine service cost limitations were determined at 112 percent of the mean national average for FYEs through September 30, 1981. For base FYEs after September 30, 1981, the routine service cost limitation was set at 108 percent of the mean national average. The lower limitation for the latter hospitals was due to changes in federal regulations.

Data to evaluate the routine service cost limitation is contained in the Medicare/Medicaid cost report. For Medicaid, Schedule D-1, Part II contains the RSCL information; Line 60 contains costs to be compared to the routine limit. The costs on Line 60 contain all the direct and indirect costs assigned to the routine cost center, with depreciation and medical education costs backed out. These routine costs are then compared to the routine limit times the Medicaid routine days, with the lower of the actual routine costs or the costs determined by the limit carried forward in determining reasonable costs.

II. Methodology

The proposed limit for routine service costs is to be at 104 percent. This percentage provides for sufficient reimbursement to an economically efficient operation for two main reasons. The first reason is that the reimbursement is 104 percent over the national mean for similar hospitals. Using a national mean is important because it provides a broader screen for Wisconsin hospitals than Wisconsin-specific indices. Secondly, 104 percent of the routine limit is the median average and the mean average for the 140-hospital sample of Wisconsin hospitals. In other words, 50 percent of the hospitals were able to control their costs so that the limitation would have no effect on their reimbursement.

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The EEO adjustment uses the current HCFA bed size categories for deriving the peer groups, which are:

Non-SMSA	SMSA
1. Less than 100 beds	1. Less than 100 beds
2. 100-169 beds	2. 100-404 beds
3. 170 and over beds	3. 405-684 beds
	4. 685 and over beds

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APPENDIX VI

OCCUPANCY LEVEL TARGET

I. Introduction

A significant contributor to escalating hospital costs is "excess bed capacity," (i.e., underutilization of inpatient hospital services). Several explanations have been offered for the underutilization of inpatient hospital services, including: the "building boom" of the late 1940s caused by the availability of Hill-Burton financing; the passage in the mid 1960s of the Medicare/Medicaid programs and their resulting "carte blanche" payment of all incurred operating expenses (causing another "building boom"); the emphasis on decreased inpatient length of stay through the PSRO function; the shift to greater outpatient utilization; and population shifts.

Whereas many of these explanations are valid, the fact remains that steps must be taken to alleviate excess capacity if cost containment is to be successful. Estimates of the costs of an unoccupied bed have ranged from 30 percent to 70 percent of an occupied hospital bed, due to the fixed costs of operation which are incurred no matter what the volume level is.

The occupancy level target is premised on the argument that Medicaid should not reimburse the fixed costs associated with unreasonably high levels of excess capacity. Therefore, an occupancy target based on total approved hospital beds is devised so as to limit hospital reimbursement to the costs incurred by an efficiently and economically operated (EEO) hospital. In other words, the amount of excess capacity to be tolerated and reimbursed would only be that amount found in an EEO hospital.

A key difference between this target and the targets described above should be noted. This target is based on settlement year occupancy data and costs while the other maximums are all taken from the base year cost report. This is the case since occupancy levels vary from year to year. Due to this timing difference, there will be no overlapping of the costs between this and other targets.

II. Methodology

The following steps will be used for deriving an occupancy target for each hospital.

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STEPS:

A. From the settlement year Medicaid Cost Report, take total patient days (excluding nursery days) and divide by total bed days available (total approved beds x 365 days) to obtain an overall hospital occupancy level.

B. Compare the overall hospital occupancy level, as determined in Step A, to the sixtieth percentile of that hospital's applicable peer grouping. The peer groupings that will be used are:

1. 50 - 99 bed SMSA hospitals;

2. 50 - 99 bed non-SMSA hospitals;

3. 100-bed and over SMSA hospitals; and

4. 100-bed and over non-SMSA hospitals.

Note: All hospitals with fewer than 50 beds will be exempt from the application of the occupancy target, in recognition of the fact that their ability to control their occupancy levels is limited. Also, many of these hospitals are in small, rural communities where guaranteeing access to health care is a primary public policy objective.

For those hospitals that have an overall actual occupancy percentage below their applicable peer group's sixtieth percentile, proceed to the following steps.

C. Determine the percentage effect of costs over the target in the following manner:

$$1 - \frac{\text{Actual Occupancy Percentage}}{\text{Target Occupancy Percentage}} = \%\ \text{Effect.}$$

D. From the settlement year cost report, take the costs for all routine service and special care unit cost centers from the last column of Worksheet B.

E. From Form F, line 26 of the settlement year Medicaid Indexed Rate Calculation Workpapers, obtain the fixed costs percentage.

F. Determine total excess fixed adult and pediatric costs (including special care) by multiplying results of Step C x Step D x Step E.

G. Determine the Medicaid inpatient reimbursement effect by taking the total excess fixed costs determined in Step F and dividing by total hospital inpatient expenses in the settlement year (Worksheet B, Last Line, Last Column - Outpatient Costs). Apply this percentage to base year Medicaid inpatient costs.

Attachment VIA lists the data requirement and their corresponding source documents; Appendix VIB shows a hypothetical illustration.

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